Crisis Intervention Teams in Maine's Androscoggin County Jail: A Report on the Early Stages of Implementing a New Corrections-based Practice Working with Mentally Ill Offenders

By the Public Health Research Institute

Abstract

In 2003, Maine's Androscoggin County Jail started Crisis Intervention Team training for its corrections officers. This article assesses initial implementation efforts and makes recommendations for future practice.

Keywords: Crisis Intervention Teams, jail, Maine.

Introduction

Crisis Intervention Teams (CIT) were originally developed as a pre-booking jail diversion program to improve police officer responses to people with mental illness, to reduce arrest rates, to reduce officer and community injuries, to reduce the use of restraints, to reduce emergency room admissions, and to improve community and officer satisfaction. Due to the high number of incarcerated persons that are diagnosed with mental illnesses and/or substance abuse problems and the possible jail crises (e.g. suicide attempts, aggressive and violent behavior) that may result, NAMI Maine, the Androscoggin County Sheriff's Office, the Androscoggin County Jail, St. Mary's Hospital, the Common Ties/100 Pine Street Social Center, and Tri-County Mental Health Services revised CIT for implementation in a jail setting as a crisis recognition, response, and management program. Within this context, CIT-trained corrections officers would recognize crisis events and carry out intervention strategies that result in normal and sustainable inmate behavior more frequently than non-CIT trained corrections officers.

The Public Health Research Institute (PHRI), based at the University of New England in Portland, Maine, was retained to evaluate the adaptation of this evidence-based police response to community psychiatric crises at the Androscoggin County Jail in Bangor, Maine. In this evaluation, PHRI used pre- and post-program data to evaluate the impact of adapting the CIT model within a jail setting. Data were extracted

from standard incident reports collected by the jail, from focus groups with CIT and non-CIT trained corrections officers, and from CIT-related incident reports and medical forms. The results reported in this article are from reports kept on CIT-related files at the jail. Additional post-CIT training data overlapped with the information presented in this article, allowing for the collection of information not documented in CIT reports and medical forms and for a before-after comparison of the CIT program's implementation. These data will help determine the effects of CIT in a jail setting, as well as illustrate gaps within the program and allow for the development of recommendations to further the use and effectiveness of the CIT program.

Androscoggin County Jail

The Androscoggin County Jail (ACJ) was selected to participate in the CIT program in the fall of 2003. Following completion of the training, ACJ corrections staff developed a CIT report form that would allow all trained corrections officers to record CIT-related incident information in a standardized format. The report serves two purposes: It eases data collection and documents CIT incidents for jail records. The CIT-trained officers use the ACJ CIT report, which includes information on date and time, location of incidents,, inmate name and date of birth, names of officers and supervisors involved, the presence or diagnosis of mental illness, threat assessments such as suicide ideation, suicide attempt, self-abuse, aggressiveness, substance use such as alcohol, heroin, methadone, marijuana, or cocaine, use or level of force, the CIT officer narrative, Tri-County referral, disposition, and CIT officer and supervisor signatures, when called to assist in a crisis situation related to mental illness and/or substance abuse. A CIT incident spreadsheet, which includes information on date and time, inmate names, type of incident, officer and supervisor names, and medical treatment, was also developed in Microsoft Excel to keep track of basic information regarding each CIT associated incident. The ACJ CIT report form initially did not include use of force, but later editions contain this indicator. The ACJ Use of Force Report was completed for two incidents prior to this revision. Information was also extracted from the ACJ Medical / Mental Health Referral forms and the TCMHS Western Crisis Services Outcome Recommendation forms only when these forms were attached to the original ACJ CIT Report. The jail referral form is to be completed every time an inmate is referred to the medical / mental health department and the TCMHS form should be completed and kept on file when an inmate is seen by TCMHS. Inmates may have been seen by or referred to the jail medical staff or TCMHS without having these forms filled out. The majority of information for each CIT incident came from the ACJ CIT Report, additional medical information was obtained from the jail medical / mental health and/or the TCMHS forms.

Results

The following results reflect only the information recorded in the ACJ CIT incident excel spreadsheet, ACJ CIT reports, ACJ medical / mental health referral forms, use of force reports, and Tri-County Mental Health Services (TCMHS) Western Crisis Services outcome recommendation forms.

From December 17, 2003 through October 31, 2004, 39 CIT related incidents were recorded by ACJ staff, although only 33 ACJ CIT reports were kept on file. Incident data for all 39 incidents include time, day of the week, and the frequency by month. All other data was compiled from the 33 ACJ CIT reports and other forms. Frequencies and percentages were computed for each incident and not for individual inmates, as the same person may have been involved in an incident more than one time. Records show that three inmates had two recorded ACJ CIT reports; all other inmates were reported only once.

Incident Time and Day of the Week

The majority of incidents (reported using six-hour military time intervals) occurred during evening hours (38%, 1700-2300) or during late night/early morning hours (46%, 2300-0459). No CIT incidents were recorded from 1100 through 1659 in the afternoon (Table 1). Although there was a wide spread of incidents that occurred across the days of the week, Thursday (23%) and Sunday (21%) were the most common (Table 2).

Table 1: **Time of Incident**

Time	Number	Percent
2300-0459	18	46
0500-1059	6	15
1100-1659	0	0
1700-2300	15	38
Total	**39**	**99**

Table 2: **Day of the Week of Incident**

Day of the week	Number	Percent
Monday	4	10
Tuesday	6	15
Wednesday	3	8
Thursday	9	23
Friday	4	10
Saturday	5	13
Sunday	8	21
Total	**39**	**100**

Frequency of Incidents by Month

The frequency of incidents by month shows active use of CIT skills through April 2004, with peak usage in March, which then drops to one or two reported CIT incidents per month through September (Table 3). This distribution may reflect the difficulties that an organization such as a jail faces when implementing a program like CIT. The ACJ initially trained corrections officers with the intent to have at least one CIT-trained officer on duty during each shift. The ACJ experienced a decrease in CIT trained officers to other employment and other reasons, leaving the jail with only five trained officers by October 2004. The

supervisor who had initially led the CIT program at ACJ left for other employment and was replaced with a non-CIT trained supervisor after June 2004.

The lack of staffed CIT-trained officers on each shift and a decline in the use of CIT interventions contributed to the decreasing number of CIT interventions. Reduced acceptance of the CIT program by other correctional officers and supervisors, as reported during a focus group session at ACJ, is an additional factor. The decline in the number of CIT officers, lack of respect by other correctional officers, and decrease in use of CIT skills has resulted in diminished enthusiasm by those who were initially trained. We note, however, that CIT-trained officers continue to strongly support CIT and believe it is an important program that should be expanded throughout the ACJ.

Table 3: **Frequency of Incidents by Month**

Month	Number	Percent
December 2003	5	13
January 2004	8	21
February 2004	4	10
March 2004	10	26
April 2004	3	8
May 2004	1	3
June 2004	1	3
July 2004	2	5
August 2004	1	3
September 2004	1	3
October 2004	3	8

Incident Location and Diagnoses

The majority (76%) of the incidents occurred in Admissions; the remaining eight incidents occurred in Holding or in another location within ACJ. The CIT-trained corrections officers examined and questioned each inmate for various types of mental health illnesses. In the majority of cases, the diagnosis recorded was based on inmate reports of their history and current status, although some are from CIT officer observations (Table 4). The incident reports indicate a litany of diagnoses that require a variety of interventions, including medication, correctional officer awareness of methods for handling these individuals, and crisis responses for those who are uncooperative or uncontrollable at intake. Table 4 lists the type of disorders reported, the number of each, and the percentage out of all 33 incident reports. Multiple diagnoses were recorded for the majority of inmates. Overall, bipolar disorder is the most commonly reported mental illness (42%), followed by schizophrenia and manic-depressive disorders.

Table 4: **Mental Health Diagnoses**

MH Disorder	Number	Percent
Bipolar disorder	14	42
Schizophrenia [1]	6	18
Manic Depressive	6	18
Depression	5	15
PTSD	4	12
ADHD	3	9
Other	5	15
Total[2]	**43**	

[1] Includes Paranoid Schizophrenia

[2] Total includes more than one disorder with a single inmate

Substance Use

Within the population of recorded CIT incidents, 45 percent of inmates self-reported or were observed by a corrections officer to be substance users, a variable that contributes to problem behaviors. Of those who were substance users, Table 5 shows the type, number, and frequency of the use of alcohol, cocaine, marijuana, and oxycontin. Inmates may be using more than one of these substances in combination.

Table 5: **Substances Used by Inmates**

Substance	Number	Percent
Alcohol	14	93
Cocaine	2	13
Marijuana	2	13
Oxycontin	2	13

Threat Assessment Behaviors

Examination of four "threat assessment" behaviors from the ACJ CIT report showed that this population is of high risk as 94 percent indicated suicidal ideation (Table 6). In addition, 18 percent had a recorded suicide attempt. Aggressive behavior and self-abuse were often reported, and the majority of inmates had a combination of more than one of the four behaviors listed, showing that the potential for disruptive incidents and/or the occurrence of a dangerous event is high. Only two incidents had recorded restraint use – in both cases the inmate was placed in a restraint chair. The restraint chair allows the inmate to be immobilized during the period of his or her uncontrollable behavior.

Table 6: **Inmate Threat Assessment Behaviors**

Type Behavior	Number	Percent
Suicidal Ideation	31	94
Suicide Attempt	6	18
Aggressive	11	33
Self-Abusive	8	24

Incident Outcome

The ACJ CIT report form also shows whether an inmate was referred to Tri-County Mental Health Services (TCMHS). Although 61 percent of incidents checked that a TCMHS referral was made, only 27 percent of the incidents had a Tri-County Mental Health Services Western Crisis Services outcome recommendation form attached, while 30 percent of the inmates were described as being seen by TCMHS. This shows either that referrals are made and not followed up with a visit or that documentation is not kept on file when an outside provider sees an inmate. In addition, most inmates were referred to the ACJ medical/mental health staff (52%), but only 18 percent of the incidents had an ACJ medical /mental health referral form attached to the incident report, again illustrating the need for consistent documentation when a referral is made. The corrections officer disposition or narrative of the incident outcome included a variety of additional response options (Table 7). The majority of incidents had more than one option recorded.

Table 7: **Corrections Officer Disposition of Outcome**

Response Option	Number	Percent
High suicide watch	5	15
Suicide watch	15	45
Close observation	5	15
Jail medical/mental health referral	17	52
Refused to talk with crisis worker or TCMH	4	12
Seen by TCMH	10	30
Sent to St. Mary's	2	6
TCMH notified	2	6
Listed as aggressive	2	6
Unknown/Other	2	6

Recommendations

The CIT program at the Androscoggin County Jail was developed to improve corrections officer awareness and response to inmates who are diagnosed with a mental illness and/or substance abuse problems, which may lead to a variety of positive outcomes including a reduction in jail crisis events and repeated inmate crises, a reduction in the use of restraints, an increase in appropriate referrals to and feedback from outside healthcare providers, and improved officer satisfaction. These data show that it is possible for trained CIT officers to recognize and respond to inmates who exhibit mental illness, but that without sufficient support the CIT program cannot be effectively implemented. Support from within the jail, including supervisors, administrators, and all officers, and support from outside agencies (e.g. TCMHS, police department, local attorneys, etc.), in addition to routine training sessions for the CIT officers, will greatly assist in keeping the program active.

The dramatic decline in the record of CIT interventions over the 11-month period since the CIT training session shows that the ACJ CIT officers are not being called upon as often by their peers and that they are not being encouraged to address a crisis as CIT-related and assist appropriately. Additional reasons may have contributed to this decline as well. The lack of medical documentation in follow up prohibits jail medical / mental health staff from treating and managing inmates with mental illness because they are not informed and shows that the relationship and communication with TCMHS needs to be improved as well. PHRI has developed a list of the following Action Steps that serve as recommendations for the future implementation of CIT in a jail setting:

- *Train additional staff in CIT*: Cover shifts adequately so that a CIT officer is available to be called upon any time, even in times of staffing shortages.
- *Assign CIT Supervisor*: The CIT Supervisor should be thoroughly trained and held accountable for managing the unit, including routine training, problem resolution, standards of performance, information exchange and access, welfare of CIT Officers, etc.
- *Follow up with CIT trained officers*. Incorporate routine in-service training sessions to continually upgrade skills and knowledge, including internal jail staff and external agencies (e.g. NAMI, healthcare providers, police departments).
- *Implement CIT Meetings*. Hold regular CIT meetings for CIT trained officers and jail administration and supervisors to discuss specific cases, discuss and resolve barriers, and promote the professionalism of CIT in a jail setting.
- *Update/Develop jail policy for CIT use. D*etermine when a CIT officer will be called upon to conduct an intervention.
- *Update/Develop jail policy for CIT designation.* Solidify the status of all CIT-trained officers based on their additional skills and knowledge. Modify jail policy to reflect when, where, and why CIT-trained officers should intervene based on their training. Improve jail staff awareness of these officers and the CIT program, emphasizing the value of the program to the Sheriff's Office and jail. Reduce ridicule of CIT and instead motivate all staff to participate and assist with its use.
- *Update/Develop recording process.* The system in place to record CIT interventions should capture information on all inmates involved in a CIT incident from intake to discharge.
- *Determine CIT Assignments*. When a CIT intervention occurs, assign the CIT Officer in charge to the inmate's case for follow-up in collaboration with other internal and external organizations and services. Allow for more than an initial assessment, and more of a client relationship.
- *CIT Intervention/Case Reviews.* CIT Officers, a NAMI representative, and a jail medical / mental health staff member, as well as other pertinent service providers should meet periodically to review CIT interventions/cases and the CIT process. Generate a regular report of CIT interventions and outcomes, accessible through the developed CIT recording process, and submit the report through the chain of command up to and including the Sheriff. Reward those officers and jail staff who consistently show leadership and exemplary behavior with the use of CIT.
- *CIT Program Reviews*. Conduct periodic evaluation of the program in its entirety to determine its effectiveness, applicability, and utility. Include jail personnel, inmates, assessment accuracy, treatment or program recommendations, outcome measures, change initiatives implemented, and existing needs and problems.

Conclusion

It is important that the jail builds a strong foundation to support the CIT program, including support from the administration and supervisors. This will lead to continued use of the skills and knowledge obtained through the training and ongoing improvements within the jail. Areas for further research include an examination of the differences in assessment and referral decisions of disruptive inmates by CIT and non-CIT trained officers to determine if CIT training results in the same, more, or less sustainable improvement with respect to inmate behavior.